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**Author names:** Bywaters, P. , McLeod, E. , Fisher, J. , Cooke, M. and Swann, G

**Title:** Good intentions, increased inequities: developing social care services in Emergency Departments in the UK.

**Article & version:** Pre-print version

**Original citation & hyperlink:**

Bywaters, P. , McLeod, E. , Fisher, J. , Cooke, M. and Swann, G. (2011) Good intentions, increased inequities: developing social care services in Emergency Departments in the UK. *Health and Social Care in the Community*, volume 19 (5): 460-467  
<http://dx.doi.org/10.1111/j.1365-2524.2011.00988.x>

**Publisher statement:**

This is the pre-peer reviewed version of the following article: Bywaters, P. , McLeod, E. , Fisher, J. , Cooke, M. and Swann, G. (2011) Good intentions, increased inequities: developing social care services in Emergency Departments in the UK. *Health and Social Care in the Community*, volume 19 (5): 460-467, which has been published in final form at  
<http://dx.doi.org/10.1111/j.1365-2524.2011.00988.x>

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## **Good intentions, increased inequalities: developing social care services in Emergency Departments**

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Words: 4626 + Abstract

## Good intentions, increased inequalities: developing social care services in Emergency Departments

### Abstract

Addressing the quality of services provided in Emergency Departments (EDs) has been a central area of development for UK government policy since 1997. Amongst other aspects of this concern has been the recognition that EDs constitute a critical boundary between the community and the hospital and a key point for the identification of social care needs. Consequently EDs have become the focus for a variety of service developments which combine the provision of acute *medical and nursing* assessment and care with a range of activities in which *social care* is a prominent feature. One approach to this has been the establishment of multi-disciplinary teams aiming to prevent re-attendance or admission, re-direct patients to other services, or speed patients through EDs with the aim of providing improved quality of care. This study, was the first national survey of social care initiatives based in EDs and aimed to determine the objectives, organisation, extent, functions, funding and evidence on outcomes of such interventions. Eighty three per cent of UK Type I and II EDs responded to the survey. Approximately one third of EDs had embedded social care teams, with two thirds relying on referrals to external social care services. These teams varied in their focus, size and composition, leadership, availability, funding and permanence. As a result, the unintended effect has been to increase inequalities in access to social care services through EDs. Three further conclusions are drawn about policy led, locally based service development. Nevertheless, this survey adds to international evidence pointing to the potential benefits of a variety of social care interventions being based in EDs and justifies the establishment of a research programme which can provide answers to key outstanding questions.

## **Good intentions, increased inequalities: developing social care services in Emergency Departments**

### **Introduction**

In the UK, addressing the quality of service provided by NHS Emergency Departments (EDs) has been a central focus of government policy since 1997. Against a background of a continuing decrease in the number of NHS beds and an increase in emergency admissions (Department of Health 2000), there has been a 6% per annum rise in new ED attendances in recent years, a growth rate which is mirrored in many other developed countries (see [http://www.performance.doh.gov.uk/hospitalactivity/data\\_requests/a\\_and\\_e\\_attendances.htm](http://www.performance.doh.gov.uk/hospitalactivity/data_requests/a_and_e_attendances.htm)). As the authors and colleagues have discussed previously, reducing ED attendances and waiting times in ED have been key issues in the UK government's 'modernisation' programme for health services (Authors' own 2005). A review in 2004 showed that there were multiple factors that can change attendance rates and that it is therefore extremely difficult to untangle possible causal factors (Authors' own 2005). Prolonged waiting times in EDs have been a major cause of patient dissatisfaction in the UK and around the world (Trout *et al.* 2000; Cooke & Jenner 2002). Capacity within various social care, primary healthcare and secondary care settings and ease of access are significant contributors. This issue is exacerbated out of hours and during holiday periods when access to alternative primary care and intermediate services is reduced (Kellerman *et al.* 1994; Jaarsma-van Leeuwen *et al.* 2000; Bianco *et al.* 2003; Trzeciak *et al.* 2003; Taylor *et al.* 2004; Patel & Vinson 2005). There is also evidence linking longer waits with poorer outcomes (Derlet & Richards 2000) and increased violence in EDs (Stirling *et al.* 2001).

However, both in the UK and internationally, work to improve ED services has not only focused on the patients' experience *in* EDs and the efficiency and effectiveness of ED service delivery from an organisational perspective. (See, for example, reports from Australia (Moss *et al.* 2002), the USA (Yeaw & Burlingame 2003) and Canada (Guttman *et al.* 2004).) It is also recognised that EDs represent a critical boundary between the community setting and the hospital, between living independently at home and acute hospital care, a key point of access not only for health but also social care (McLeod and Olsson 2006). As such, EDs play an important role (alongside general practitioners) in determining who enters hospital and how transitions between home and hospital are managed. Admission avoidance is an important issue in the NHS and a systematic review has shown it can also reduce the chance of dying and increase patient satisfaction, although its impact on carers is unknown

(Shepperd et al. 2008). The existing literature has addressed hospital at home type interventions (for example, Hardy et al 2001) rather than focussing on admission avoidance by improved social care at the time of an acute hospital presentation. EDs are also potentially key sites for identifying the social care needs of those patients for whom hospital admission is not required on medical grounds and anticipating social care requirements post-discharge.

Consequently EDs have become the focus for a variety of service developments which combine the provision of acute *medical and nursing* assessment and care with a range of activities in which *social care* is a prominent feature (Gordon 1999). Social care is taken here to encompass a wide range of 'activities, services and relationships that help us to be independent, active and healthy, as well as to be able to participate in and contribute to society, throughout our lives' (HM Government 2008: 7). Access to such care is associated with a number of reported benefits to both patients and institutions, including improvements in short and longer term physical and psychological well-being (McLeod *et al.* 2003), reduced ED re-attendance, reduced emergency admission (Cooke *et al.* 2005) increased patient satisfaction (Olsson & Hansagi 2001), and cost-effective acute hospital care (Gordon 2001, Gamboa *et al.* 2002).

In the UK this focus on social care services delivered in or through EDs has been reflected during the past decade and more in a range of both national and local policy initiatives. These achieved public prominence in the late 1990s and early 2000s because of the problems created for the NHS by so-called 'winter pressures' on acute hospital beds and accompanying political difficulties. In the summer of 1997, Alan Langlands, Chief Executive of the NHS, and Herbert Laming, the Chief Social Services Inspector, visited each of the eight NHS Regions to meet with staff from health and social care services to discuss what plans were in place for the provision of services in the coming winter. Their report (Langlands & Laming 1997) identified 'Accident and Emergency Departments' as being in the front line of pressures on the health and social care systems and that making adequate provision for emergency care was then the Secretary of State's first priority. It commended the 'whole systems' approach they had found in some regions, together with a number of specific measures such as 'rapid response' nursing teams, 'hospital at home' and 'home from hospital' schemes, health purchased nursing home beds, adequate provision of rehabilitation services and aids and adaptations, improved out of hours services and good information systems for patients and carers. Each of these was designed to reduce demands on EDs and on the hospitals for whom they were key gatekeepers.

One aspect of subsequent service development in line with this whole systems approach has been the establishment in EDs of multidisciplinary teams delivering social care and support alongside or as an adjunct to acute medical care. Whilst the composition of teams varies, they have been reported to include combinations of the following health care professionals:

nurses, physiotherapists, occupational therapists, doctors and social workers, with a high proportion focusing on ED's role in avoiding hospital admissions (Hardy *et al.* 2001, McCusker *et al.* 2003, Walsh *et al.* 2003, Caplan *et al.* 2004, Guttman *et al.* 2005). The literature suggests such teams, and accompanying services, operate in four main ways,

- preventing avoidable ED re-attendances and acute hospital admissions by supporting patients in their own homes or in institutional or intermediate care
- deflecting patients directly to other services on arrival at ED where patients have no urgent medical problem requiring acute admission
- speeding patient throughput in ED via the timely provision of or referral to social care support services
- raising the quality of care by addressing the wider social and psychological needs of patients and informal carers attending EDs and releasing other staff from this role (Bywaters & McLeod 2003).

These teams have developed in an ad hoc way in the UK, with local interpretation of need and variations in provision. For example, an earlier survey undertaken by the authors found that about 30% of UK EDs had a social work service attached to it but with varying levels of staffing, hours of cover and types of funding (Cooke *et al.* 2000).

Despite the growth of these new models of care, literature on individual initiatives, multi-skilled roles and their potential for improvements in patient care and organisational efficiency, there is a lack of systematic evidence on the extent, objectives, organisation and function of social care services in EDs. For example, while evaluations of individual ED based social care initiatives have been published (Gagnon *et al.* 1999, Guttman *et al.* 2004), there has been no systematic literature review to synthesise the findings. In addition, the authors found in a regional survey that a number of ED based social care initiatives which had developed through pragmatic localised start-ups remained hidden because accounts of them had not been published (Authors' own 2006). If the aspirations of integrated health and social care are to be realised then a systematic account of such initiatives and their value is needed, as an initial step towards evaluating how effective they are in improving patient care.

Accordingly, this article reports a study, funded by the Burdett Trust For Nursing, which included the first UK national survey of ED based social care initiatives. Its central aim was to determine the objectives, organisation, extent, functions, funding and evidence on outcomes of such interventions. The key objectives reported here were to undertake a UK wide postal and internet based survey of all ED managers/matrons in UK hospitals with EDs to determine the extent of social care provision and to develop a taxonomy to classify all reported ED social care initiatives. As the research approach is classified as an audit, while participation was on the basis of informed consent, it was not necessary to obtain clearance through research ethics committees.

## Methodology

All UK type I (Consultant led 24-hour service with full resuscitation facilities, designated for the reception of ED patients) and II (Consultant led single specialty) EDs, as identified by the Department of Health and British Association for Emergency Medicine Survey (2007), were approached and invited to participate in the survey. Of the 287 EDs approached, 37 were identified as minor injury units or walk-in-centres (Type III) and were therefore ineligible for inclusion in the study. The remaining 250 EDs were eligible for inclusion. Of the eligible EDs, 83% (208/250) agreed to participate.

To identify emergency departments with ED-based or co-located social care interventions, a letter explaining the nature of the study and what would be required of participating EDs was sent to the following people together with a form on which to list any social care interventions:

- Senior Nurse – Emergency Department
- Physiotherapist Manager for hospital
- Social Work Lead for hospital
- Clinical Lead/Director, Care of the Elderly

Respondents listing interventions were offered the opportunity to either complete the more detailed survey by post, e-mail, the internet, or a telephone interview. Eighty two percent of EDs in England sent eligible returns (n = 162 ) between September 2007 and April 2008, 91% in Northern Ireland (n=10), 85% in Scotland (n=22) and 100% in Wales (n=14). Data were collected on a range of variables. The data were collated and analysed using SPSS 15.0 (Statistical Package for Social Sciences). Some questions were not answered by all respondents.

A post-hoc taxonomy of interventions was created as follows. All named social care interventions, both located in EDs, or based on referrals out were collated. A typology was then formed reflecting the primary functions that the most commonly occurring service provisions e.g. Rapid Response initiatives, were designed to fulfil. These were respectively: Admission Avoidance e.g. Rapid Response Teams inputting or augmenting social care swiftly, so service users could return home safely, thereby avoiding admission; Early Discharge e.g. expediting Mental Health or Self-Harm referrals to ED based or external social or psychiatric care, to avoid the ED becoming a ‘waiting room’ for service users; and Prevention e.g. referral to local Domestic Violence agency workers, to address both immediate, but also longer term problems such as the need for alternative accommodation, which would reduce the likelihood of re-presentation at ED. The category of ‘Other’ was

created from service provisions serving as an adjunct to social care interventions e.g. Interpretation services, but whose primary function was not identified as admission avoidance, early discharge or prevention from ED re-attendance. Almost without exception these services were dependent on a referral being initiated from ED (see Figure 1).

*Insert Figure 1*

An Advisory Group drawn from members of the Social Work and Health Inequalities Network, (SWHIN) an international network of health and social care practitioners and academics, convened by email, provided expert advice on the design of the questionnaire and the development of the taxonomy.

### **Findings**

Of the 208 EDs across the UK, 35 per cent ( $n=73/208$ ) had social care interventions located within the department. The remainder 65 per cent ( $n=135/208$ ) reported that social care interventions were available through links or referral pathways to resources outside the ED. Eight of the 73 EDs with in-house social care interventions had multiple social care initiatives. Five EDs had two and three EDs had three interventions. The majority of interventions, 67 per cent ( $n=56/84$ ), were solely located in the ED, with 28 per cent ( $n=24/84$ ) co-located within the hospital or local community.

These bare facts already reveal the diversity of services between EDs. In one third, one or more forms of social care services could be accessed directly by patients and carers, but in two thirds a referral to an external service was required. However, as we examined the in-house services in more detail a further range of disparities were revealed.

### **Variations between countries**

Although in some cells, numbers are small, a larger proportion of emergency departments in England and Wales directly provide social care interventions than either Northern Ireland or Scotland (Table 1). All of the four countries of the UK have more interventions directed towards admission avoidance and early discharge than preventative interventions (Table 2), but in Wales there appears to be more diversity of service provision than is the case in other countries, although the numbers are small.

*Insert Table 1*

*Insert Table 2*

### **Variations in the focus of services**

The majority of interventions, 62 per cent ( $n=52/84$ ), were designed to avoid admissions to hospital beds. Early discharge interventions, 23 per cent ( $n=19/84$ ), were the form of intervention next most commonly reported by clinical leads. Interventions designed to



prevent or reduce the likelihood of future ill-health and or hospital re-attendance amounted to 16 per cent (n=13/84).

### **Variations in leadership**

Predominantly the in-house services are lead by nurses (63 per cent, n=48/76), followed by occupational therapists (18 per cent, n=14/76), then social workers (9 per cent, n=7/76). Some of the services had shared leads (5 per cent, n=4/76) with only 2 of the services having a medical lead.

### **Variations in staffing size and mix**

The number of team members was reported for 90 per cent (76/84) of services and varied widely from 1 to 30 (Mean=3.80; Median=2.75; SD=4.57). The disciplines involved are shown in Table 3. Nurses were the most frequently mentioned team member and accounted for more staff than all other professional groups combined. Occupational therapists were the next most frequently mentioned group, then physiotherapists, followed by social workers.

A small majority of services were staffed by multi-disciplinary teams (54 per cent (n=42/78), with uni-disciplinary teams comprising 46 per cent (n=36/78). Of these the majority were staffed by nurses (34 out of 36).

Insert Table 3

### **Variations in operational hours**

The services varied in the times they were available, with only 12 per cent offering 24-hour access (Table 5). The majority of the interventions were not providing an out-of-hours service and operated only within normal working hours. Of the remainder, 34 per cent offered some out-hours provision in addition to in-hours provision although the extent varied greatly and one service only operated out of hours.

Insert Table 4

### **Variations in sources of funding**

The funding streams for the social care services undertaken in UK EDs were diverse (Table 6) and included provision by Acute Trusts, Primary Care Trusts (PCTs), Social and Mental Health Services, combinations of these organisations, voluntary and charity organisations, project grants and the Welsh Assembly.

Three quarters of services were funded either by Acute Trusts or PCTs. Some services reported joint funding between Acute Trusts, PCTs or equivalent, and Social and Mental Health Services. A small proportion of services were funded by charities/voluntary

organisations and two pilot studies were funded by project grants. Only one of 71 social care services was funded by the local authority Adult Care service.

Insert Table 5

### **Variations in permanence**

The majority of services 92 per cent (n=68/74) reported permanent team members with only 7 per cent (n=5/74) reporting teams that rotate between services. One service reported core permanent members with additional staff as and when needed from other areas of the emergency department. Only 25 per cent (n=21/74) of respondents reported receiving specific training for their role in the team.

### **Discussion and Conclusions**

As the survey only involved staff perceptions, we are not able to report on patient and carer satisfaction with these services. Two thirds of the services had undertaken some kind of evaluation but almost none of these were available for external review or were published. Not surprisingly, perhaps, given who was doing the reporting, around 90 percent of respondents identified benefits for patients, particularly in terms of avoiding hospital admission or accessing early discharge through social care support being made available. A similar proportion of respondents reported benefits for ED staff or organisational systems from having in-house social care services. Many of these reflected organisational goals, such as reducing admissions, saving time or costs and freeing up beds, but others reflected a sense of improved quality of service including better decision making, providing better follow up, increased staff skills and better linkage between primary and secondary care. Around a quarter of respondents identified reduced stress for staff arising from greater confidence that patients' needs were being appropriately met.

While there is evidence of significant innovation in these social care service developments in UK EDs in the past two decades aimed at making hospital care more efficient and effective and services better for patients, the outcome has been a patchwork of services, an extension of the postcode lottery. Of people in the UK with significant social care needs who are at risk of or in need of ED attendance, one third may be able to access social care services directly as part of their ED attendance, with two thirds relying on a referral to a service located elsewhere. However, the social care services on offer are usually reactive in their approach aiming at avoiding admission or discharge delay and much more rarely are concerned to provide proactive services to prevent deterioration in patients' circumstances or conditions. And frequently, the possibility of accessing direct services in those EDs which have on site provision depends on the time of day or night that the patient attends. In

contrast to the 24 hour access to EDs, only 9 out of 208 hospitals had a ED based social care service which operated on a 24hour basis.

Furthermore, every other aspect of the in-house services on offer is a matter of local practice. The focus of the service (or services), which professions are involved in providing it, how many of them there are, who leads the team and how it is funded all vary widely. While a survey such as this cannot find evidence which links provision to the level of social advantage or disadvantage in the population served, it is clear that equality of access to service provision does not exist.

Moreover, there is little or no evidence of a systematic attempt to find out which of this plethora of individually designed services has benefits for whom at what cost? While some studies have been conducted internationally into the impact of particular kinds of intervention these have been limited in a number of important ways (see discussion in Bywaters and McLeod 2003):

- They have almost always focused on the outcomes of a particular service rather than comparing different services or the mix of services in any particular context
- They have usually focused on individual EDs rather than making comparisons between EDs running different patterns of service
- They have usually taken as read, a particular pattern of staffing and funding, rather than comparing alternatives
- They have similarly not compared the impact of different opening hours, or other organisational differences, rather, evaluating the service on offer in the particular ED in which the research took place.

In addition to highlighting the evident urgent need for a strategic research initiative to clarify some of these issues, there are at least three broader lessons to be drawn from this survey of ED based social care developments. First, there is the obvious point that it cannot be assumed that service development and improvement will lead to greater equality in access to services. (This would require that provision equalised up to best practice as services were evaluated and found to be effective or otherwise.) Indeed the reverse should be assumed unless a strategic approach is taken to evaluation and subsequent policy review. While the evidence from staff in this survey and from staff and patients in other studies is largely positive about EDs as a good location for identifying people's needs for a mix of health and social care services, allowing services to develop purely in an ad hoc way cannot be right. It is hard to imagine the outcry which would follow if 208 hospitals decided to develop their own prescription drugs and medication regimes as has been done for social care interventions. If these services are valuable to patients and cost effective, they should be available on the basis of need and perhaps other criteria for entitlement, not according

to the creative initiative of individuals or hospital Trusts. Local variations could be expected but only within a broadly equal framework.

Second, it cannot be assumed that when developments are encouraged, research and audit will be embedded in these initiatives which clarifies which kinds of service patterns do have the best outcomes for patient care, effectiveness and efficiency. The way that such services have been funded in the UK, often initially as short term initiatives, together with the perceptions of what constitutes the 'gold standard' in research makes this less than likely. In essence, social care interventions rarely take the form of a single discrete action which can be randomly compared with other actions or no action at all. Social care services usually involve – and indeed the personalisation agenda (Department of Health 2006) suggests should always involve – tailoring a mix of possible services to the individual.

Third, it cannot be assumed that policy makers who initiate and fund processes of service development on a national basis will be concerned to build new service policy on the back of such disparate and localised experiments. The tension between central and local control is an ever present fault line in policy making. It is particularly apparent in the UK in relation to the NHS, where the competing policy priorities of local involvement in decision making and equity in access to services are repeatedly reflected in public debates about a post-code lottery of provision.

Nevertheless, this survey adds to international evidence pointing to the potential benefits of a variety of social care interventions being based in EDs and justifies the establishment of a research programme which can provide answers to the following key outstanding questions. Which patterns of social care services, staffed by what number and combination of professionals, open during which hours, based within EDs or elsewhere and linked to other services in what ways, best meet the long and short term needs of both ED service users and carers and the health and social care organisations that provide or commission the services? What are the costs of different configurations? In the absence of answers to these questions, as our survey has shown, inequalities in provision and experience will continue to be the norm.

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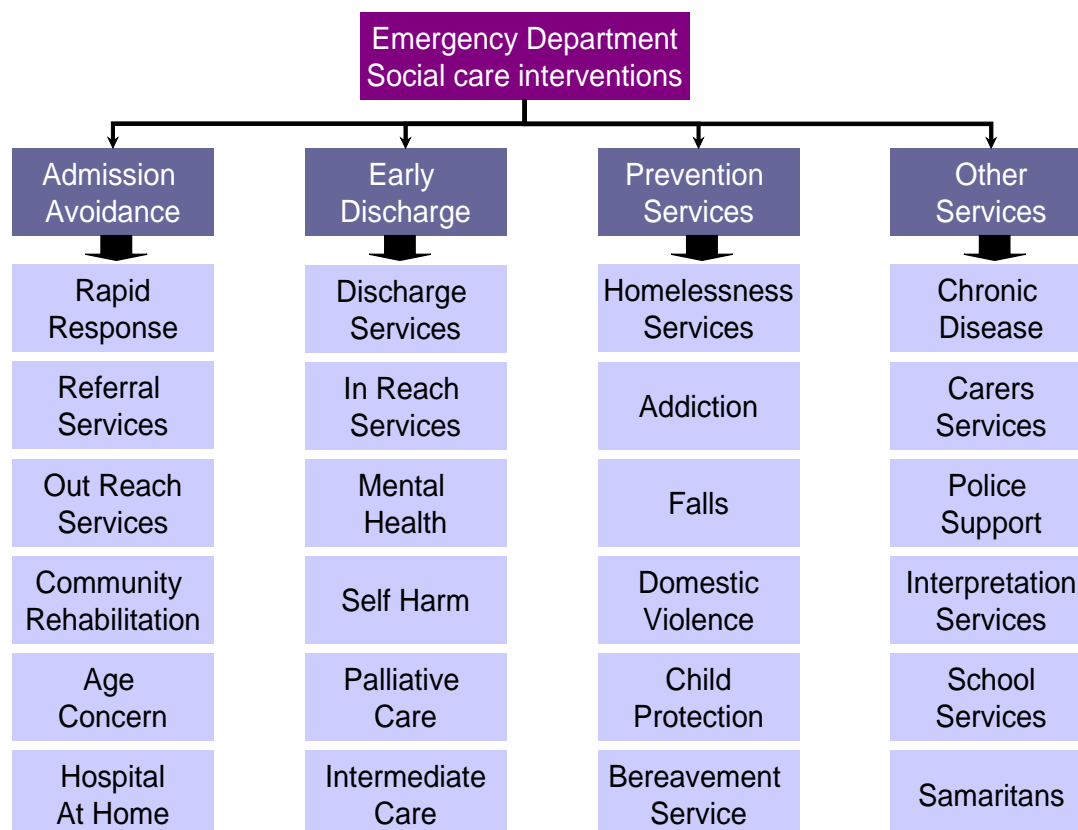
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**Figure 1: Typology of primary functions of most common social care interventions reported by EDs.**





**Table 1 – Social care interventions by Country**

Country	interventions located or co-located in ED
England	44% (n=72/162)
Northern Ireland	20% (n=2/10)
Scotland	18% (n=4/22)
Wales	43% (n=6/14)

**Table 2 – Number and percentage of interventions by category for each country**

Country	Admission Avoidance	Early Discharge	Prevention Interventions
England	46	15	11
Northern Ireland	1	1	0
Scotland	4	0	0
Wales	1	3	2
<b>Total:</b>	<b>52</b>	<b>19</b>	<b>13</b>
	<b>62%</b>	<b>23%</b>	<b>15%</b>

**Table 3 – Professional disciplines of team members**

<b>Staff disciplines</b>	<b>n</b>	<b>%</b>
Nurse	59/76	77%
Occupational therapist or OT assistant	53/76	70%
Physiotherapist or physiotherapist assistant.	35/76	46%
Social worker	25/76	33%
Manager	3/76	4%
Clerical	2/76	3%
Doctor	2/76	3%
Dietician	1/76	1%
Speech therapist	1/76	1%

**Table 4 – Service Availability**

<b>Service availability</b>	<b>n</b>	<b>%</b>
In-hours <sup>1</sup> only	41/77	53
In-hours with some Out Of Hours provision	26/77	34
24-hours	9/77	12
Out-of-hours <sup>2</sup> only	1/77	1

1. 7.30 – 17.30 Monday to Friday

2. 17.30 – 7.30 Monday to Friday; all day Saturday, Sunday and Bank Holidays.

**Table 5 – Funding stream for services**

<b>Funding source</b>	<b>n</b>	<b>%</b>
Hospital Trusts	27/71	38
PCT or equivalent	27/71	38
Joint funding (PCT, Health Board/Hospital Trusts/Social/Mental Services)	12/71	17
Project Grant	2/71	3
Social Services	1/71	1
Voluntary/Charity	1/71	1
Welsh Assembly	1/71	1